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Huisman, A.; Robben, P.B.M.; Kerkhof, A.J.F.M.

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Use of Guidelines in Suicide Prevention

To the Editor: An interesting study by Huisman and colleagues (1) in the January issue described the suicide audit system of the Dutch Health Care Inspectorate. All suicides in the Netherlands are reported to the inspectorate, which follows up on some reports with requests for additional information or with remarks or suggestions for improving services. The study investigated whether the feedback provided by the inspectorate was in agreement with guidelines of the American Psychiatric Association (APA) (2) for assessment and treatment of suicidal patients.

Because the study period was from 1996 until 2006, it is not realistic to expect the responses of the Dutch Health Care Inspectorate to follow guidelines for most of the study years, because the guidelines were not published until 2003. The APA guidelines appear to have been used as a theoretically constructed gold standard. However, this requires further clarification.

As noted in the study, the Dutch Health Care Inspectorate sometimes gave quite detailed feedback to the providers of care, such as emphasizing the importance of telling the patient about an elevated suicide risk in the first weeks after starting antidepressant medication. However, it remains to be seen to what extent American guidelines are applicable in the Netherlands at this level of detail. For example, given restrictions on the possession of firearms in the Netherlands, checking the accessibility of firearms is less important, even though it is repeatedly mentioned in the APA guidelines.

Thirty percent of the persons who committed suicide in the study sample were inpatients. It is important for psychiatric hospitals to check that ligature points are absent (3), although this is not mentioned in the APA guidelines because of the emphasis in this document on the role of individual psychiatrists. Feedback to hospitals from the inspectorate about the need to check for the absence of ligature points would reinforce the role of this agency in suicide prevention.

The findings of the study would have been even more impressive if a standard of care based on the current literature had been used to analyze the responses of the inspectorate, rather than the APA guidelines.

Dieneke Hubbeling, M.Sc., M.R.C.Psych.

Dr. Hubbeling is a consultant psychiatrist at South West London and St. George's Trust, United Kingdom.

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In Reply: We thank Dr. Hubbeling for her response, and we are happy to clarify our choice of the APA guidelines. First, no Dutch national guidelines for the treatment of suicidal patients exist. Therefore, we knew beforehand that we could expect that the inspectorate's notifications and responses would not follow any existing guidelines. However, we needed a standard of good clinical care for suicidal patients so that we could evaluate the inspectorate's responses. For this reason we conducted a literature search and screened all guidelines available internationally. The review was published in Dutch in 2007 (1).

Because the APA guidelines are the most extensive that we know of and are partly evidence based, we chose them as a gold standard, as Dr. Hubbeling observed. However, it is important to note that it was our intention to use only the most global recommendations and not to compare the inspectorate's responses with every detail in the APA guidelines. Most of the primary and general points in the APA guidelines, such as continuity of care and systematic risk assessment, are very much in line with major recommendations in the other guidelines that we reviewed.

We agree that there are many more important aspects to suicide prevention, such as checking for the absence of ligature points in inpatient facilities and other more detailed recommendations for specific treatment settings. Also, we agree that further research on good clinical practice is necessary to develop and maintain an up-to-date standard as a reference for the inspectorate's responses. Partly as a consequence of our study of the suicide notification procedure, a multidisciplinary guideline for the treatment of suicidal patients, which will be used by the inspectorate, is being developed in the Netherlands.

Annemiek Huisman, M.Sc.
Paul B. M. Robben, Ph.D.
Ad J. F. M. Kerkhof, Ph.D.

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Physical Injuries From Restrictive Interventions

To the Editor: The findings of the study by Martin and colleagues (1) in the December 2008 issue—that use of restrictive interventions can be reduced through a collaborative problem-solving model—are both interesting and exciting. Steps taken to decrease the use of such interventions are to be welcomed and should be reinforced on an international scale. It is unlikely, however, that such interventions will be completely eradicated from psychiatric services. Therefore, debate and discussion on ways to reduce the risks of such interventions are important.

One reason for reducing the use of restrictive interventions is that the evidence base for their safety and effectiveness is distinctly lacking (1). In addition, individuals who apply the interventions and those to whom they are applied may experience many adverse psychological consequences (2). Patients may view the interventions as unwarranted and as punishment for their actions (2). They may also report that such interventions cause pain, which all care providers should seek to avoid. Staff may experience anger and anxiety, and in some cases staff may reawaken memories of their own untoward experiences (2).

More recently, researchers have explored the physical consequences that such interventions may have for both parties. Clearly, the most serious physical consequence is death, and Martin and colleagues describe such cases in the United States. Another obvious consequence is injury to both staff and patients. Research on this important topic is limited, but one U.K. study of a medium-secure unit published in 2003 found that nearly one in five incidents of physical restraint resulted in injury to staff or patients (3). Two more recent studies found that the prevalence of such injuries was considerably lower (4,5), even though the patients in these studies, older adults and persons with acquired brain injury, respectively, typically have a far more complex physical presentation than seen on a general adult medium-secure ward.

These studies found that employing a physical therapist who screened all patients for physical ailments that would increase the likelihood of injury or pain was central to reducing patients' injuries. If any ailments or restrictions on activity were identified, the physical therapist worked with the hospital's physical restraint tutor on adopting pain-free techniques. Restrictive measures must be used with caution when they involve children and adolescents because in most cases their musculoskeletal systems are immature, which elevates the risk of injury. Individuals who apply such interventions in populations at risk of pain and injury might consider involving a physical therapist to reduce risk.

In summary, all staff should seek to reduce the use of restrictive interventions for the good of both patients and staff. Employing a physical therapist to screen patients is one way to reduce the risk of pain and injury. My U.S. colleagues might consider taking this approach.

Brendon Stubbs, B.Sc., P.G.Dip.

Mr. Stubbs is clinical specialist and lead physiotherapist at St. Andrews Healthcare, Northampton, United Kingdom.

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